



ST. JOHN'S EPISCOPAL HOSPITAL

EPISCOPAL HEALTH SERVICES INC.

Clinical Pastoral Education

Excellence in Training for Competent Compassionate Pastoral Care

APPLICATION FOR CLINICAL PASTORAL EDUCATION

Name: _____ Date of Birth: _____

Office Address: _____ Work Tel: _____
 Street Town State Zip Code

Home Address: _____ Home Tel: _____
 Street Town State Zip Code

E-mail Address: _____ Pager #: _____ Cell Phone: _____

Marital Status: _____ Children 's Ages: _____

Faith Group/Denominational Affiliation: _____

Association/Conference/Diocese/Synod/Presbytery: _____

Current Professional Position: _____ Are you ordained? _____ If "yes", give date: _____

	<u>EDUCATION</u>	<u>DEGREE</u>	<u>DATE</u>
College:	_____	_____	_____
Seminary:	_____	_____	_____
Graduate Study:	_____	_____	_____

PREVIOUS CLINICAL PASTORAL EDUCATION OR OTHER SUPERVISED CLINICAL TRAINING

Dates	Center	Supervisor
_____	_____	_____
_____	_____	_____
_____	_____	_____

REFERENCES & ADDRESSES (Please include zip codes & phone numbers):

Denominational: _____

Academic: _____

Other: _____

ATTACH THE FOLLOWING ITEMS TO APPLICATION

1. A **reasonably full account of your life**, including important events and relationships with persons who have been significant to you , and the impact of these events and relationships have had on your development. Describe your family of origin, your current family relationships, and your educational growth dynamics.
2. A **description of your religious life**, including events and relationships that affected your faith and currently inform your belief systems.

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3. A **description of your (vocation) history**, including a chronological list of positions and dates.
4. A **description of an incident in which you were called to help someone**, including the nature of the request, your assessment of the "problem", what you did, and a summary evaluation. If you have had previous CPE include this information in verbatim form.
5. *Your impression* of your previous clinical pastoral training(s) [i.e., clinical pastoral education and/or other supervised clinical training experiences], if any. What are your impressions and *expectations* of the program to which you are seeking admission? How will this training be used to further your goals for doing ministry? Indicate if this training is required of you, and if so, by whom.
6. A description of any special needs you will have during the training (e.g. disability considerations, transportation, housing, financial).
7. Application fee of \$30.00. Make checks payable to "EHS-CPE".
8. A recent photograph (optional).
9. An "Admissions Interview Report" by a CPE Supervisor or other qualified person. Admissions Interview conducted by:

Name: _____

Address: _____

THOSE WITH PREVIOUS C.P.E. SHOULD COMPLETE THE FOLLOWING

10. *Copies of previous C.P.E. evaluations* written by you and your supervisor.
11. What was the most *significant learning experience* in your previous C.P.E. and how have you continued to work in this learning method? Illustrate your strengths and weaknesses as a professional person.
12. What are your personal and professional goals and how will continued training aid that process?
13. Documentation of Faith Group Endorsement (Required only from applicants for *Supervisory CPE*)

APPLICATION FOR: [Check (✓) as applicable]

FULL-TIME CPE UNIT: (Eleven Weeks)

WINTER SPRING SUMMER FALL

PART-TIME CPE UNIT: (Extended CPE, 2 days/evenings each week for 9 months)

DAY PROGRAM EVENING PROGRAM

RESIDENCY:

Full-Time, 12 Months, 3 CPE-Unit Credits

TRAINING LEVEL:

CPE SUPERVISORY CPE

TRAINING SITE PREFERRED:

FAR ROCKAWAY BROOKLYN D NO PREFERENCE

DAYS PREFERRED: Check two: MON TUE WED THU FRI

There is *no* assurance your choice can be successfully accommodated

EARLIEST DATE YOU CAN BEGIN: _____ Social Security #: _____

Date: _____ Signature of Applicant: _____

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